

WOODROW WILSON REHABILITATION CENTER
Fishersville, Virginia 22939-1500
POSTSECONDARY EDUCATION REHABILITATION TRANSITION
PHYSICAL-HEALTH QUESTIONNAIRE

Student _____ ID # _____
ID # to be completed by WWRC Staff

1. Has the student had a medical hospitalization in the past year?
☐ Yes ☐ No

a) If yes, please explain the circumstances.

b) Is the student's medical condition currently considered stable?

- c) What implications does this medical condition have for this student's participation in the PERT program, specifically, addressing vocational evaluation, dormitory living, and recreation?

Completed by: _____
Relationship to Student _____
Phone _____ Date _____

WOODROW WILSON REHABILITATION CENTER
POST SECONDARY EDUCATION TRANSITION PHYSICAL-HEALTH QUESTIONNAIRE

Student _____ ID # _____
ID # to be completed by WWRC Staff

The client named below is scheduled to receive a comprehensive vocational evaluation at Woodrow Wilson Rehabilitation Center beginning _____. The duration of the evaluation is ten (10) consecutive days, including nights, in a comprehensive residential setting. **A routine student schedule is attached to this form for you to review.** Because medical resources at the Center are limited, we require the following documentation be received by the WWRC PERT Program prior to admission:

1. Medical Tolerance Assessment
2. Physician's statement regarding this client's general health, physical limitations and restrictions.

These completed documents may be given to the DRS Field Counselor or faxed directly to the PERT Program at 540-332-7298.

Client's Name: _____ Date of Birth: _____

Address: _____

Phone: _____

Client's Parent's/Guardian's statement of limitations: _____

Functional/Environmental Limitations: (Please check all that apply)

Walking	<input type="checkbox"/> Unlimited	<input type="checkbox"/> 1-2 miles	<input type="checkbox"/> ½ -1 mile	<input type="checkbox"/> 1-2 blocks	<input type="checkbox"/> 100 ft. or less
Stairs	<input type="checkbox"/> Unlimited	<input type="checkbox"/> 4 flights	<input type="checkbox"/> 2 flights	<input type="checkbox"/> 1-2 flights	<input type="checkbox"/> None
Lifting	<input type="checkbox"/> 60-100 lbs.	<input type="checkbox"/> 40-60 lbs.	<input type="checkbox"/> 25-40 lbs.	<input type="checkbox"/> 10-25 lbs.	<input type="checkbox"/> 10 lbs. or less
Standing	<input type="checkbox"/> Unlimited	<input type="checkbox"/> 75% of time	<input type="checkbox"/> 50-75%	<input type="checkbox"/> 25-50%	<input type="checkbox"/> 10% or less
Stooping, bending, twisting	<input type="checkbox"/> Unlimited	<input type="checkbox"/> Restricted	<input type="checkbox"/> Avoid		
Temperature extremes	<input type="checkbox"/> Unlimited	<input type="checkbox"/> Restricted	<input type="checkbox"/> Avoid		
Vigorous Recreation Activities (bowling, swimming, skating, basketball, etc.)	<input type="checkbox"/> Unlimited	<input type="checkbox"/> Restricted	<input type="checkbox"/> Avoid		

Other Limitations: _____

Comments and Recommendations: _____

Physician's Name _____ Specialty _____